

Psychosocial Aspects of Cancer

During the National Conference of Social Work sessions at Chicago in May, the American Cancer Society sponsored discussions of the psychosomatic and psychosocial aspects of cancer under the general title, "Living With Cancer." Public Health Reports publishes here two papers dealing with professional and patient attitudes. Other papers concerning reactions to surgery and community implications and attitudes will follow in later issues.

Professional Attitudes and Terminal Care

By CHARLES S. CAMERON, M.D.

The problem of terminal care for patients with cancer presents an increasing responsibility of a magnitude that, perhaps, is not fully appreciated by those in whom the responsibility is rightfully vested. The marked increase in longevity for both men and women in this country within the past few decades means that more and more persons are living to the age when cancer is most common. Cancer, once eighth in the list of causes of death, is now superseded only by heart disease and is thus second among the causes of death from disease in the United States. More cancer is being cured today, but more people live to have cancer. And the need to know the requirements of patients whose disease is beyond control is a major one for all those responsible for giving them adequate care.

Dr. Cameron, medical and scientific director in the American Cancer Society, New York City, presented this paper at the American Cancer Society's program, National Conference of Social Work, Chicago, May 27, 1952.

At the present time in the United States there are 210,000 deaths annually from cancer. At any one time in this country there are 32,300 persons with a condition that may be called "terminal cancer." We become more aware of what this means when we realize that in any community of 10,000 persons there are 14 deaths from cancer annually, and in any such community, at any one time, there are theoretically two or three individuals for whom terminal care should be provided.

While these figures state the problem and provide an understandable frame of reference, they are actually only the barest approximation of reality since terminal cancer is so varied in its manifestations and in its practical and actual significance. The protean nature of cancer, as it manifests itself clinically, makes the term "terminal" almost unsusceptible of rational definition. Cancer is not one predictable disease. Terminal cancer presents the physician with a series of situations, varied, unpredictable, and often bizarre, and the care of these patients offers an opportunity for the practice of all of the arts and the science of medicine.

There is no similarity between the clinical manifestations of the onset of cancer of the lip and cancer of the rectum, and there is the same enormous variation in the mode of exodus of the patient. Cancer of the breast may terminate with metastases to lungs and to bone and present problems of management completely at variance with, say, the patient whose cancer of the stomach is followed by nutritional problems, cachexia, and terminal hemorrhage. Between such extremes lies the spectrum of terminal disease, made extremely broad by the many anatomical sites of cancer and the many degrees of growth activity included in the term "cancer." Technically, terminal care begins at that moment when it is accepted, after careful study, that the patient's disease cannot be controlled.

"Calls for" Services

For the purpose of considering professional attitudes "terminal" may be defined broadly as that period in the course of cancer which is characterized by progressive invalidism that calls for professional or quasi-professional services, given regularly and frequently.

That part of the definition which bears most directly on professional attitudes is the phrase "calls for professional or quasi-professional services." The term is not "requires" as in emergency complications about which there is no question of the importance or value of professional attention. It is not "demands" in the sense that the patient with superior resources accepts, pays for, and gets the best medical, nursing, and custodial care.

The simple, almost homely, phrase "calls for" best expresses the needs of a large segment of those patients with advancing cancer—those who depend on the service of the general practitioner and whatever ancillary ministrations their dwindling resources permit, and those who, through gradations of indigency, must look to public welfare and to voluntary agencies.

The fact is, today, that response to this need is remarkably diverse. I have recently been impressed by this diversity during a visit to two city cancer hospitals. One is a new building associated with a large cancer center and a teaching hospital. The second is one of those

which are called "cancer hospitals" but appear to descend from the era of the pesthouse. In the first hospital an enthusiastic and zealous staff conscientiously fights and overcomes the attitudes of despair, frustration, abandonment, and rejection which abound in the second hospital where the terminal cancer patient is barely endured as a hopeless, helpless, and frequently unpleasant problem for whom routine, uninspired, and often cursory custodial care is doled out. An understanding and appreciation of the final outcome of inoperable, incurable cancer should not preclude a lively struggle on the part of all concerned, including the patient himself, to preserve integrity and maintain the best possible physical status until the final and overwhelming onslaught of disease.

In the first hospital, research along many fronts is under way, and active treatment for all patients is the rule. I do not believe that research activity alone is responsible for the encouraged attitude of the patients, but I do believe that the attitude of those who care for these patients—doctors, nurses, social workers, recreational workers, and volunteers who help perform a myriad of tasks—is all important. Such attitudes of professional personnel are not limited to facial expressions, tone of voice, conversational content, or even to expressions of extraordinary interest in the patient's welfare. More importantly, I believe, such attitudes are expressed in active treatment which assures and convinces the patient that he has not been abandoned. Each new complaint, each succeeding sign of deterioration is regarded not as an indication for increased use of morphine sulfate but as a challenge to professional skill and an opportunity to relieve or ameliorate distress.

Response to Nutritional Improvement

That a great deal of the cancer patient's distress can be relieved is not wishful thinking. It can be accomplished by the intelligent and confident application of what we now know about the care of these people. We can improve their nutrition and watch them gain in weight and in morale. Patients with malnutrition all suffer anorexia, which in itself sustains the mal-

nutrition. No amount of encouragement or coaxing induces these patients voluntarily to consume the necessary caloric requirements. For many of them, the institution of tube feeding for certain periods of time is life-preserving. They will show rehydration, a gain in weight, and then to some degree an increase in strength. These gains will be followed by a return of appetite. Tube feedings may then be stopped and the patient will continue to eat substantial quantities of food. Subsequent to this, serum albumin and hemoglobin levels increase. The length of time necessary for restoration of appetite following institution of tube feeding is roughly proportional to the degree of existing malnutrition and varies from 1 to 6 weeks, with an average of 2 to 4 weeks. Elman of St. Louis has recently shown the advantages of aggressive dietary regimens, and to him I am indebted for permission to cite the following examples:

N.B.: 46-year-old female, diagnosis carcinoma of cervix, stage 4. Initial diagnosis in 1942; became stage 4 in 1950. Prior to patient's coming to us, she had weight loss of 40 pounds, anorexia, nausea, and vomiting, and was bedfast. Hematocrit 28; serum albumin 3.3. Tube feeding was instituted and continued for 36 days. At the end of this time she ate voluntarily 2,800 calories daily. At this time she showed a 16-pound weight gain, was ambulatory, felt much improved, and was completely free of symptoms. Narcosis was no longer necessary. Hematocrit 38; serum albumin 4.1. At this time she returned to her home ambulatory, taking care of herself, participating in family affairs. At the end of 6 weeks patient became moribund because of cerebral hemorrhage (probably secondary to metastases).

L.C.: 71-year-old female; diagnosis carcinoma of cervix, stage 4. Above diagnosis made in 1949. At time tube feeding was instituted, patient had lost 36 pounds, was bedfast, had anorexia, and was extremely weak. During one week's observation she ate practically nothing voluntarily, even with encouragement. After tube feeding for 49 days, she had regained 23 pounds, was ambulatory, free of all symptoms, and not taking any narcotics. She was hungry and able to take 3,400 calories from the tray. One week later she was discharged to her home able to care for herself and participate in family affairs. In the past 5 months she has gained another 35 pounds, is working, and is asymptomatic.

These illustrate clearly the difficulty in defining any hard and fast answer to the question "what is terminal?" And they underline the importance of sustained, aggressive treatment.

The Physician's Attitude

Some representative attitudes of physicians toward terminal cancer may be illustrated by several selected vignettes. The attitudes of physicians, I believe, condition the outlook of all persons on the professional team—nurses, technicians, social service personnel, dietitians, and occupational therapists. But all must share in the effect of the attitudes on patients and others.

Dr. A is by nature reticent and introverted, and is almost as depressed in the presence of cancer as the patient. His experience has deepened his instinctive gloom—having to care for a few terminal patients each year has been heavily dispiriting. His philosophy of "what's the use?" virtually atrophies scientific initiative and action. He does as little as possible—and offers irrational excuses for his inertia.

Dr. B's basic attitude is similar to A's. However, he hides a distaste for terminal cancer behind a mask of magnanimity. The essence of his philosophy is: "There is nothing I can do, therefore, it is unfair of me to come here day after day and take your money." Thus, he palms off his lack of interest and resourcefulness as a virtuous unwillingness to accept money under conditions where he can do no good.

Dr. C is kind, sympathetic, cheerful by nature. However, he has little intellectual or scientific interest in clinical cancer. But he tries to make up for his technical inadequacies by pulling out all the stops of his personality. The result is that the more critical the situation grows, the more jovial he becomes. This is fine while it lasts, but the truth is that most patients with cancer, which grows harder to bear each day, sooner or later conclude that this daily 10 minutes of optimism and encouragement is hardly enough for 24 hours.

Dr. D was brought up in a stern stronghold where honesty, frankness, and candor were esteemed above all other traits. He is the opposite of Dr. C. He believes that the major problems of terminal cancer can be dissipated by telling the patient the brutal truth, and does not recognize that what is one man's meat is another's poison. The delicate nuances of neurosis are weaknesses to be suppressed by any self-respecting patient and ignored by any self-

respecting physician. He insists that his practice of telling the patient the facts will correct the egocentric unbalance of a lifetime. Although he does help some, he does about as much damage as he does good, as is the case with anyone motivated by an inflexible dogma.

Dr. E. is thoughtful, studious, yet also considerate and understanding. He appears to the patient and the patient's family to show the same fresh interest at every visit. He obviously wants to visit the patient, and he treats each new difficulty as nothing more than a nuisance which needs to be abated, and which will be, if he has anything to do about it. Above all, the fundamental thesis of his approach is: "There is practically nothing that can happen to the patient until the moment of his death which I cannot engage and improve." More prosaically, he believes that while there's life, there's hope. And his conviction that he can make the rough places smoother is born of experience and study. He has at his fingertips eight different ways to make food more interesting to his anorectic patient. He knows five methods for keeping the patient's room free of odors from fecal drainage. His judicious and graded use of analgesics, narcotics, and hypnotics gives him means to counteract pain adequately, even for months on end, and he regards the routine use of morphine as admission of his own ignorance. He is informed as to the value of occupational and recreational therapy as means of converting a dreary, bored existence into a reasonable facsimile of interested, integrated living. He takes nothing for granted and the stronger the presumptive evidence of hopelessness, the more aroused is his therapeutic combativeness. He will not give up.

The feature common to the first three physicians was a lack of interest in terminal cancer—a state of mind which reflected itself in apathy and inaction. The fourth was mechanically resourceful and interested, but he spoiled it all by disregarding the all important attitude expressed in the word "tact." The final example combined inquiry, imagination, and persistence to the distinct advantage of the patient.

There is one grave danger in adopting the attitude of compromise in caring for any patient—even the patient with advanced and seemingly hopeless cancer. Such compromise may

become expedient at some point in the course of cancer. But where shall that point be designated? If it seems best to give up in one case, why not in the next? If prolonging life appears normally unsound in one case, will the same not hold in the next one? When shall the doctor and his team slacken their efforts? Who shall say when the battle is over? The danger is obvious: To reduce therapeutic effort at any time, under any circumstances, is to endorse partial "therapeutic nihilism." It is not an unattractive expedient. It saves work, and better yet, it saves worry. Of course, full commitment to that practice would save the doctors all worry—and incidentally, all work. Obviously, the safest and fairest therapeutic method is to regard every living cancer patient as susceptible of improvement.

New Agents for Pain Relief

This plea for continuous and unremitting interest in the problems of terminal cancer might, as recently as 10 years ago, have been regarded as an altruistic but quite unrealistic exercise. The advances of medicine, which began with World War II, have left little legitimate base for such a view today.

I have referred to the aspect of nutrition. There are others of importance. While few would claim that meticulous attention to fluid and salt equilibrium, protein balance, and vitamin requirements is as important in terminal case management as it is in the postoperative patient, it is still of first importance to the patient, whatever his status.

The pain of advanced cancer can often be controlled by the exercise of professional imagination and ingenuity, and at the same time the problem of drug dependence or addiction can be obviated or greatly lessened. Surgical nerve sectioning procedures, such as prefrontal lobotomy, chordotomy, rhizotomy, and nerve injection, have their places, and when properly selected can reduce intractable pain to bearable proportions. Dependence on morphine for pain relief over long periods is as regrettable as it is unnecessary. A dozen drugs are at hand. The thoughtful use of them in succession and in graded amounts will avoid the sledge hammer effect of morphine sulfate with its too

frequent result—personality disintegration. In one institution hypnosis is being explored as a means of pain control, and the early results are at least interesting. Pain in cancer is often an effect of infection in the tumor or its adjacent area. The control of such infections is frequently the equivalent of pain control. Indeed, in selected cases antibiotic and bacteriostatic agents are as effective as narcotics in achieving pain relief.

The prolongation of useful, comfortable life following administration of indicated hormones is well established. The place of chemotherapy as distinguished from hormone therapy is limited, yet within a narrow spectrum of usefulness a few drugs do accomplish unique results. Hodgkin's disease, sometimes lymphosarcoma, leukemia, cancer of the lung, and plasma cell myeloma are susceptible to one or another of the chemotherapeutic agents. Radioisotopes, while not living up to the hopes expressed for them 5 years ago, are, under special circumstances, the treatment of choice. The wider use of supervoltage X-rays and their application to tumors with new precision techniques, such as rotation of the patient beneath or before the tube, and the therapeutic use of other forms of high energy radiation, as the betatron, are bringing a greater measure of relief to those with inoperable advanced cancer. The psychiatrist and the clergyman can give some individuals the help which no amount of physical or medical maneuvering can, and the physician who would offer every possible benefit to his patient will be alert to these services.

All these things have narrowed the margin called "terminal." Yet their potential of usefulness is far from realized.

I plead for a perpetual spirit of inquiry toward the advanced cancer patient. We know little enough, and we are never justified in adopting a pontifical or complacent attitude as though the answer were known and the course of the disease adequately forecast. Obviously, danger lies in glib or routine predictions concerning how long a particular patient may expect to live, and the fact that such predictions

are so often wide of the mark sometimes leads families to question the competence of those who make them. It is important that the physician who accepts the responsibility for a patient with terminal cancer obtain a careful history covering the entire course of the patient's illness, and perform a meticulous and critical physical examination. Not infrequently a diagnosis of inoperable cancer may be made by one physician, whereas a colleague with perhaps more experience may find the cancer amenable to treatment with at least a theoretical chance of cure. Too, it has happened that a diagnosis of cancer was made when no cancer was present. Errors in interpreting X-ray films and failure to obtain pathological proof of the existence of cancer can account for mistakes in diagnosis and unwarranted hopeless prognoses. It is important that nothing be taken for granted and that each patient be afforded a critical review.

There is one additional reason why every patient with advanced and hopeless cancer should be sustained by the active interest and care of his doctor until the inevitable exodus occurs: to protect the patient, and his family, from the charlatans and quacks who invade the fringe of medicine and offer hope and promise where they are not justified. When physicians shirk or neglect the care of their advanced cancer patients, it is inevitable that the patients turn to those who hold out encouragement and promise. The harm done by these quacks is incalculable. Patients are defrauded of money and denied the comfort and sustaining care which should be provided by their physicians' interest and skill.

More experience, more research, and more time will bring still other and more effective support and relief to the cancer patient in the terminal phases of his disease. But they will come, as all medical progress has come, only to those with minds which are actively seeking any and every means to improve a seemingly hopeless prospect. They will never come to the mind resigned to the inevitable.